Bulletin 171
[Short]

Commissioner's file: CI 2553 2001

DECISION OF THE SOCIAL SECURITY COMMISSIONER

1 I allow the appeal.

2 The appellant is appealing with my permission against the decision of the Liverpool appeal tribunal on 2 April 2001. The tribunal decided that the appellant suffered a loss of faculty from prescribed disease A11 (commonly known as vibration white finger) from 1 January 1999, and that the resulting disablement was 8% for life.

3 For the reasons below, the decision of the tribunal is erroneous in law. I set it aside. I refer the appeal to a new tribunal to determine in accordance with the directions in this decision.

The facts

4 The appellant had for over 25 years and still was engaged in work involving vibrating tools. He was advised by his consultant to give up that work but had not done so. The diagnosis and date of onset of A11 are not in dispute. The dispute concerns solely the assessment of disablement. Diagnosis was confirmed by an examining doctor. Blanching occurred both summer and winter to the full extent of all four fingers on each hand. Prognosis was static. The appellant reported pins and needles throughout both hands apart from the thumbs. Grip in both hands was reduced to 75%, and there was loss of dexterity. There was also eczema of the palms and bilateral Dupuytron's contracture. Disablement was assessed at 8%, on the basis of 1% per finger for life.

The assessment of disablement

5 The appellant's solicitors appealed by letter dated 14. 12. 2000. In a detailed submission based on both their own experience and on the prescribed degrees of disablement in the Social Security (General Benefit) Regulations 1982 ("the Regulations") . The solicitors argued for a percentage award of 26% to 32%, with an alternative argument for 50%. The argument for 26% was based on a comparison with the tariff for a guillotine amputation of the tips of all eight fingers (twice 5%, 4%, 2% and 2%). The argument for 32% was based on taking 64% as the separate figures for loss of the whole of each of the fingers of both hands (14%, 12%, 7% and 7%) and discounting by half. The argument for 50% was based on the tariff figure of 50% for the loss of all four fingers of a hand, again discounted by half. The letter was referred internally within the Department to a medical adviser with the comment to the effect that 8% seemed out of line with the level of disablement. An explanation was also requested of the 1% per finger approach.

6 The relevant part of the medical adviser's reply was:

"Traditionally VWF has been assessed at 1% per whole finger affected. However with the advent of DMA new MAF guidance was introduced, copies of which I enclose... The history and physical findings for the client fit with the middle of the 6% to 10% MAF range so 8% is appropriate. There is no evidence of loss of tissue from the fingers as a result of VWF so more than 10% is out of the question here."

I set out the relevant part of the enclosed MAF (medical assessment framework) guidance as Appendix 1 to this decision.

7 The papers went to the tribunal with a consultant rheumatologist's report on the appellant. This confirmed pain in the hands, problems with grip, multiple discolouration, attacks several times a day lasting several minutes, and pins and needles. The consultant stated that he was having nerve conduction tests performed to see if there were other contributed factors such as carpel tunnel syndrome. The tests had been carried out by the time of the tribunal hearing, but the result was not known.

The tribunal decision

8 The tribunal held an oral hearing. It recorded that it did not examine the appellant. It also recorded a clear recent history of the problems of the appellant and repeated that in its statement. It indicated that it accepted the appellant's evidence of his disablement. The appellant had had to give up a number of activities and might have to give up work. The pain was the worst aspect, and woke him up during the night.

9 The tribunal agreed with the assessment of 8%. Its reasons are as follows:

> "The tribunal gave careful consideration to the assessment of the appellant's disablement ant took account in particular of the written submission of the [solicitors] of 14.12.00 and the Medical Advice submission [the MAF extract]. For the reason set out below the tribunal does not accept the proposed method of assessment in the letter from [the solicitors].
>
> The tribunal assessed the disablement caused by the prescribed disease A11 at 8% for the period from 16. 4. 1999 for life. In reaching the assessment the tribunal has taken into account the following factors:
> (1) the evidence as a whole of the appellant;
> (2) the medical examination carried out at the hearing by the medical consultant member of the tribunal (clinical findings are on a separate sheet) and the clinical experience and expertise of that member;
> (3) the fact that the appellant is still continuing in his job as a labourer involved in structural piling;
> (4) it is possible that the appellant may also be suffering from carpel tunnel syndrome; some of his symptoms (eg waking up at night with pins and needles in his hands) do point to a carpel tunnel problem and it is noted that [the consultant] would also appear to be considering this; if this was diagnosed the appellant should make a fresh claim in respect of the prescribed disease (this was explained to him at the hearing); any disablement caused by possible carpel tunnel syndrome has been excluded from the current assessment;
> (5) the prescribed degrees of disablement set out in Schedule 2 of the Social Security (General Benefit) Regulations have been taken into account as a guide; the tribunal does not, however, agree that the degree of disablement should be equated to the guillotine amputation of the tip of the finger because this is a totally arbitrary method of assessment and it is not what was laid down in the legislation for the assessment of disability arising from prescribed disease A11;

also amputation involves a permanent loss and also disfigurement (which is not the case with vibration white finger);
(6) in the view of the tribunal 8% is a fair assessment of the appellant's current disablement."

Grounds of appeal

10 The grounds of appeal challenged the conclusion of the tribunal on the analogy with amputation, drawing attention to regulation 11(8) of the Regulations. Attention was also drawn to the permanent loss of sensation and use. The solicitors also challenged the relevance of the fact that the appellant continued at the same job. The appellant had been advised by his consultant to give up work. In directions while granting leave, I drew the attention of the parties to Commissioner's decision CI 499 2000. I also directed comments from the Secretary of State on the solicitors' objections to the MAF and on the tribunal's objections to the solicitor's use of the Regulations. I also drew attention to the possible relevance of the judicial guidelines for the assessment of general damages published by the Judicial Studies Board.

11 The Secretary of State's submission supported the appeal by the appellant on several grounds. It agreed that the tribunal did not deal adequately with the arguments put by the solicitors. It agreed that the tribunal failed to explain clearly what was the basis of the award of 8%. It agreed that the tribunal failed to make clear whether it felt constrained by the parameters of the MAF. And it agreed that the tribunal did not make clear whether the assessment included the effects of both vascular and neurological damage following CI 14532 1996. There is a detailed reply for the appellant. It agreed with each of the comments made by the Secretary of State's representative. It invited the Commissioner to make his own decision. It suggested, in place of previous arguments, that an appropriate approach might be to take disablement of 1% for each little finger as the starting point, leading to a progression of an additional 1% for each other finger (ie 1%, 2%, 3% 4%), giving 10% for each hand or 20% overall.

My decision

12 I agree with all the submissions from the Secretary of State's. Paragraphs (1) and (6) are of the tribunal's reasons are patently inadequate as an explanation of the decision. Paragraph (2) conflicts with the actual record of proceeding, which states that there was no medical examination. Nor is there any indication on the record of proceedings that this is an incorrect statement. Nor is there any added sheet of clinical findings as stated in that paragraph. Nor is there anything specific in the record that appears to be derived from such an examination or sheet of findings I also agree with the criticism of paragraph (3). The clear medical advice was to give up the job. The appellant explained how he had managed to keep going despite that advice. There is no comment about that advice or evidence in the decision. The tribunal took the wrong view over other possible contributing factors in paragraph (4), and the wrong view about the Regulations in paragraph (5). It is entirely the wrong approach to reject the references to the Regulations as "totally arbitrary". That is not what regulation 11(8) of the Regulations provides. The decision must be set aside.

13 I was invited by the solicitors to take my own decision. For the reasons I explained in CI 1307 1999, assessment of disablement under the Social Security Act 1998 is no longer exclusively a medical matter. The combination of that view, together with the view taken by the tribunal in CI 1307 1999 that no medical examination was necessary, formed the basis of my decision in that case to make my own assessment. But I did so after an oral hearing at which the appellant was present and answered questions from both me and the Secretary of State's representative. Neither party asked for an oral hearing in this case, and I do not consider it appropriate to make an assessment in this case based only on the papers. I therefore refer the appeal to a new tribunal.

Guides to assessing disablement

14 The papers contain considerable information about the assessment of disablement in prescribed disease A11 cases. There are, in my view, three general sources of guidance that a tribunal may consider. The first and most important is the statutory guidance of the Regulations on which the appellant's representatives relied and on which the Secretary of State's representative has now commented at length. The second is the MAF. The previous tribunal failed to deal properly with either of these guides. I drew attention to a third guide in my directions. This is the book of guidelines drawn up by the judges themselves for providing a consistent basis for awarding general damages in personal injuries cases.

The statutory guidance

15 In R(I) 5/95, a case about prescribed disease A11, Commissioner Rowland noted that the Regulations do not provide assistance in all cases "but the present is the type of case where a tribunal might well find it useful to consider the Schedule" (paragraph 16). I agree, and add that I think that additionally important now that Departmental decisions are made within the MAF in many cases. Both parties have now made full submissions about assessing A11 as against specific levels of disablement in the Regulations, and I must therefore comment on them. The following can, in my view, be drawn from Schedule 2 to the Regulations. Loss of one hand is 60%, and loss of both hands is capped at 100% (on the tariff, it would be 120% if the hands are assessed separately). As to the fingers, loss of four fingers of one hand is 50%, showing that most of the loss of a hand is related to the fingers. Loss of all fingers is also 100%. Loss or disablement of the index finger is assessed at twice the equivalent loss or disablement of a ring or little finger, showing that the "1% per finger" approach is wrong in law. Loss of all four fingers is assessed at 10% more than the separate loss of fingers individually, showing that the loss of the whole is to be assessed more highly than the loss of the parts, again showing the "1% per finger" approach to be wrong. I agree with both parties that at the upper extreme the nearest equivalent to the disablement from A11 is probably the guillotine amputation of the tips of the relevant fingers (see the MAF in Appendix 1 and the solicitors' letter at document 37). That is a loss of the flesh of the tips (and therefore the sensory use) without loss of bone or major deformation. That puts an upper limit on disablement by comparison at 26% if all 8 fingers are affected on a permanent basis. If that is so, then I reject the attempt by the medical adviser to impose a limit on disablement at 10% in the absence of tissue loss (see paragraph 6 above) as unjustified by reference to the Schedule. But, as the Commissioner commented in R(I) 5/95, "it must be borne in mind that the fact that a condition is

only intermittent or episodic should be reflected in the assessment." A tribunal must therefore assess how extensive the disablement is in frequency and duration to make the comparison.

The Medical Assessment Framework

16 At the time the tribunal heard this case the MAF had not been published, although the Secretary of State's representative rightly added part of the MAF to the papers. The relevant part is in Appendix 1. Since then, the MAF has been published, in electronic form. It can be found under "resources for medical practitioners" at www.dss.gov.uk/publications/dss/2001/medical/maf2001.htm. It now has a more thorough introduction, but it does not make entirely clear the basis for the specific levels of advice on assessment given. Are they an attempt (similar to that noted below by the judges) to draw general conclusions from previous individual cases or are they in the form of advice about the levels that the Department considers right?

17 Whatever the answer for the levels set for A11, the basis of assessment set out in MAF is both wrong in law and incomplete. It follows that the suggested levels of disablement are or may be too low overall. The guidance assumes that any neurological deficit is either O-pre or O-post. That is, it is a separate contributing factor to that of the physiological loss following from A11. That is wrong. Commissioner's Decision CI 14532 1996, paragraph 17, made it clear that once A11 is diagnosed, the assessment of disablement is to take account of both physiological and the neurological disablement. That is particularly important in a case such as this, where the appellant's main complaints were about pain. If the advice given on the four bands of percentages excludes neurological disablement, then presumably inclusion of the neurological aspects increases the levels of disablement from those percentages, particularly in severe cases of pain. That is consistent with the "tariff" approach under regulation 11 of the Regulations. I agree in particular with the commentary on regulation 11(6) of the regulations in *Non Means Tested Benefits 2001* (Sweet & Maxwell) that "the disabling effect of any unusual amount of pain must also be taken into account".

18 My views on the principles to be derived from the statutory guidance are set out above. I also note that the MAF guidance excludes specific guidance of the use of 11%. That is the critical percentage under regulation 11(4) of the regulations for dealing with other effective causes arising afterwards. There is therefore no specific guidance about cumulation, although it is common for those suffering from A11 to have other physically related problems, as in this case. If disability excluding the neurological element is in the range of 6% to 10% in regular blanching cases, then presumably the assessment including the neurological element will range beyond 11% in some cases and therefore activate regulation 11(4). For those reasons, the MAF guidance on prescribed disease A11 should be treated with caution by tribunals.

Judicial guidelines on assessment

19 In reply to my direction referring to judicial guidelines, the Secretary of State's representative argued briefly (and without specific reference to those guidelines) that the comparison would be incorrect by analogy with the reasoning in my decision CI 1307 1999. This is because "the focus of other schemes is not

necessarily the same" as that of the industrial injuries scheme. In that case I refused to accept that a reference to the "general tone" of the tariff used for assessment of criminal injuries compensation was of relevance to assessment of disablement for current purposes because the two schemes were essentially different. That remains my view of that tariff, but I take the opposite view of the relevance of the judicial guidelines on general damages for pain, suffering and loss of amenity. The exercise of assessing damages under those heads has much in common with the current exercise.

20 The current judicial guidelines are in *Guidelines for the Assessment of General Damages in Personal Injuries Cases* (Blackstone Press on behalf of the Judicial Studies Board, 5th edition, 2000, with a foreword by Lord Justice Waller). As the introduction makes clear, its purpose is to distil guidelines from awards that have been made, and not to promote views about what should be done. In other words, the guidelines reflect accumulated actual experience of the judiciary in approaches to dealing with assessing damages for pain, suffering, and loss of amenity in personal injuries cases. There is a close analogy to the basis for disablement benefit awards as this includes no element of compensation for loss of earnings or other forms of special damage. The guidelines reflect not only the sums to be awarded (figures of limited individual relevance to disablement benefit cases) but also guidance on how to arrive at an appropriate figure within a range of possible awards. That is precisely what the MAF also attempts to do, and precisely what the tribunal failed to do in this case.

21 The judicial guidelines have the advantage that they are neutral, and not derived from the thinking of one party to litigation. As this case illustrates, there can be a danger in an uncritical assessment by a tribunal of a decision that relies on the views of one party as to the appropriate level of disablement. The danger is that the tribunal fails, or appears to fail, to exercise its own judgment, and may adopt errors in the official view.

22 For that reason, I draw the attention of the tribunal to the guidance given on vibration white finger. I set it out at Appendix 2. It draws on the Taylor Pelmear scale set out in, and commented critically on by the Commissioner in, CI 14532 1996. The Commissioner referred more favourably to the Stockholm scale, also set out in that decision. Without entering that debate, attention is drawn to the fact that the judges have, like the MAF, formulated a four-level approach to assessment. But there is greater stress in the judicial assessment of the most serious level, and the judicial guidelines offer criteria for deciding where a particular assessment falls both within and between the levels of assessment. I do not attempt to derive anything from the bands of damages.

Assessing disablement in this case

23 In the light of the above, I direct the new tribunal as follows:

a. It must assess the level of disablement suffered by the appellant from the loss of faculty caused to him by prescribed disease A11, including both the physiological and neurological effects of the disease and also, as appropriate, disablement caused by the interaction of that loss of faculty with disablement caused for any other reason to his upper limbs.

b. It must make findings about the nature of the total relevant loss of faculty and disablement , taking into account all probable causes, and also about the extent to which that loss and disablement are attributable to the disease.

c. With regard to the loss of faculty and disablement attributable to prescribed disease A11 (by itself or with other interacting causes), it must decide how serious that loss is relative to possible levels of loss from the disease. In making that relative assessment, I direct it to take into account the specific criteria set out in the judicial guidelines, namely:

(i) length and severity of attacks and symptoms;
(ii) extent and/or severity and/or rapidity of deterioration;
(iii) age and prognosis.

d. It is to decide the specific level of assessment (or more than one level if appropriate) taking into account the arguments presented by both parties and with reference to the Regulations and to the official and judicial guidance discussed above.

e. The approach of 1% a finger used in the decision under appeal is not in accordance with the Regulations and is not to be used.

David Williams
Commissioner

28 January 2002

Appendix 1 to CI 2553 2001

Assessment of disablement from prescribed disease A11 : extract from the Medical Assessment Framework (copied from the appeal papers).

Unless the condition is very severe the disablement in VWF is not continuous. In general the symptoms and signs appear episodically. Only in very severe cases is the impairment to manual dexterity present all the time. For comparison, the amputation of the tips of all fingers of one hand would attract an assessment of 22 to 26%. However, unless there are trophic changes, there is no actual tissue loss and symptoms occur intermittently. These characteristics of the disease must be taken into account when assessing disablement.

The upper limb dysfunction identified as the disability will most commonly manifest itself as disordered or reduced manual dexterity, which in people with accompanying neurological symptoms and signs will be due to the combined effects of the vascular manifestations and the neurological manifestations. (The prescription of PD A11 includes the vascular element only, thus when a neurological deficit is established (or any other cause of upper limb dysfunction) it will be identified as an O(pre) or O(post) condition as appropriate.

Less than 1%. Not applicable. Due to the nature of the condition, by the time the symptoms are sufficiently severe to diagnose the Prescribed Disease, disablement will be at least 1%.

1 - 5%. Occasional episodic (ie less than half the days in a week) blanching affecting the middle phalanges of the fingers in both winter and summer, but more frequently in very cold weather.

6 – 10%. Regular episodic (ie occurring on most days in a week) blanching affecting the middle and proximal phalanges of the fingers in both winter and summer, but more frequently in cold weather.

Above 11% It is unlikely that the effects of VWF would be severe enough to warrant an assessment in excess of 11%. However if trophic changes are present refer to the Scheduled Assessments for loss of tips of fingers and make an appropriate addition.

The above bands assume that the condition affects both hands. Should only one hand be affected, then the assessment should be halved.

Appendix 2 to CI 2553 2001

Assessment of general damages for Vibration White Finger:
Extract from Guidelines for the Assessment of General Damages in Personal Injuries Cases, chapter 6. (Judicial Studies Board, 5th edition, published by Blackstone Press, 2000).

Vibration White Finger

This is a particular form of Raynaud's phenomenon caused by prolonged exposure to vibration. Degrees of severity are measured both on the Taylor-Pelmear Scale and on the Stockholm Scale (for the neurological aspects). From the Taylor-Pelmear Scale the relevant categories are:

(i) extensive blanching of most fingers with episodes in summer and winter of such severity as to necessitate changing occupation to avoid exposure to vibration;
(ii) extensive blanching with episodes in summer and winter resulting in interference at work, at home and with hobbies and social activities;
(iii) blanching of one or more fingers with numbness, usually occurring only in winter and causing slight interference with home and social activities;
(iv) blanching of one or more fingertips with or without tingling or numbness.

The top of the bracket will normally represent the most disabled stage 3 - 4 on the Taylor-Pelmear Scale ((i) to (ii) above). The position in the bracket will depend upon:

(i) length and severity of attacks and symptoms;
(ii) extent and/or severity and/or rapidity of deterioration;
(iii) age and prognosis.

In some cases these factors are more important than the stage the disease has reached.

The brackets can best be defined and valued as follows:

(i)	Most serious	£10,500 to £17,000
(ii)	Serious	£8,250 to £10,500
(iii)	Moderate	£2,750 to £8,250
(iv)	Minor	Up to £2,750.